ON CERTAIN UTERINE DISPLACEMENTS.

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The following cases will serve to illustrate the varied and at times severe symptoms occasionally accompanying certain uterine displacements, which are not at all uncommon, but which are often either not recognized by the physician when he makes his local examination, or considered so slight as to be of little or no importance, and not sufficient to account for the pains and aches of which the patient perhaps complains. They will also show the relief of symptoms to be afforded in many of these cases by a proper use of uterine supporters. Few physicians at the present day fail to recognize, on uterine examination, a well-marked instance of flexion or version, or a pronounced example of prolapse; but the cases I refer to are those where the uterus, retaining nearly or quite its proper axis in the pelvis, sinks lower than the normal position, yet does not descend so far as to constitute the "prolapse" of the general practitioner. That sometimes a uterus will be found so low in the pelvis that the cervix is far back in the hollow of the sacrum, resting, as it were, upon the floor of the pelvis, and yet the patient suffer little or no inconvenience, is without a doubt true; but that in other cases a much less degree of "sagging" will give rise to severe symptoms is equally the fact. The same is true of other uterine displacements. For example, every now and then a patient comes along with a perfectly marked retroversion which does not incommode her in the least, yet the physician who should reason from a case or two of this kind that retroversio uteri never caused trouble would be sadly in error.

Case I. Mrs. T., aged twenty-five, consulted me at the request of her brother, a physician, and gave the following history. She had been married within a year. Never pregnant. Menstruation, which appeared at the usual age, is always regular, but accompanied by excessive pain. She dreads its appearance, always takes to her bed at once, and is often forced to resort to anodynes, which, however, never give her complete relief. The flow lasts five or six days, and is normal in amount. The pain is most severe the first two days, but she is obliged to remain quiet the whole time, else the pain increases. Leucorrhœa not a troublesome symptom. Between her menstrual periods she has some backache at small of back "when she gets tired." Can walk a mile or more, but not without backache afterward. Micturition normal. Slight tendency to constipation, for which she occasionally takes medicine. Appetite good, and general condition excellent. She states that she was formerly treated for "stricture of the uterine canal," which she was told was the cause of her pains when unwell. The uterus was dilated with tents at short intervals extending over a number of months, but she did not derive the expected relief, and now for a long time has had no treatment.

On examination, a uterine probe, a common sound, and lastly a Peaslee sound (the largest ever used) were successively passed to the fundus without meeting with noticeable obstruction. There was marked tenderness of the interior of the uterus; for some time even the most careful use of the probe causing severe pain, which lasted for hours. The whole organ was congested, swollen, and enlarged, and occupied the position previously referred to; that is, it was low in the pelvis, the cervix tending toward the concavity of the sacrum, the normal axis being retained.

There were two conditions present, either of which might account for the dysmenorrhœa. One was the inflamed, tender state of the interior of the uterus; the other, the position of the organ. Either condition might produce the other. An inflamed endometrium would be likely to induce an afflux of blood to the whole organ, increasing its weight, and thus its tendency to sink in the pelvis; while a uterus from any cause occupying a low position is liable to a chronic hypostatic congestion, which not only may, when increased by the monthly flow of blood to the parts, be of itself a sufficient cause of dysmenorrhœa, but, as would be supposed, is often followed after a while by a congested, and later a tender, inflamed condition of the uterine cavity. Which condition was the primary one in this case could not be determined.

For a while the patient was treated with local applications to the interior of the womb, made at intervals of about a week, in order to see if the use of a supporter might be avoided. In some of these cases such treatment suffices. As the local irritation is alleviated the congestion abates; the organ, diminished in size and weight, recovers its normal position without further aid, and the patient is relieved. I have known several marked instances. Often, however, this treatment alone will not bring about the desired result. In this case the effect was not satisfactory, although there was perhaps some slight decrease in the pain at the periods, and after a fair trial I advised the resort to a supporter, and fitted one. The patient soon found that her backache was less troublesome, and that she was able to be about on her feet without getting quickly tired out, as formerly. The applications were continued for a while, until they ceased to give much pain and the uterine cavity was no longer especially tender to the touch of the sound, and then stopped.

The patient lately came back to report. She had had less suffering when unwell than ever before, some of her periods being free from all severe pain, but for the last two periods there had been pain the first day. The pessary which she had worn for months had chafed a little at one spot, and I recommended her to go without it for a short time on this account. There was some return of the intra-uterine tenderness, which will need a little attention. She finds that now, even when without her supporter, she suffers less with backache than before she wore it, but I have advised her not to attempt to dispense with its use permanently yet. Eventually, she will probably be able to do without it.

Stricture of the uterine canal is not infrequently diagnosticated as a cause of dysmenorrhœa, when in reality no "stricture" exists. When there is an inflamed condition of the lining of the womb the calibre of the canal is often much diminished by the coincident swelling, and in cases of displacement leading to hypostatic congestion the consequent œdema and swelling of the uterine tissues often leads to the same narrowing of the uterine canal, which is most readily detected with the sound in the neighborhood of the os internum, that being normally the narrow part. But to treat such cases as though this secondary condition were the prime cause of the troubles present does not seem rational.

Again, when the examiner finds difficulty in passing a sound, he is very apt to jump to the conclusion that a stricture is present, when perhaps such is not the case, and the fault is his own. Where the old-fashioned cylindrical speculum is used (and no one at the present day would base a diagnosis of stenosis of the uterine canal upon difficulty in passing the sound by the touch alone, and without the use of any speculum), it is, in many cases, an impossibility for any one to be at all sure whether a stricture is present or not; for, owing to the fact that the uterine canal is not in a line with the speculum when the latter is introduced into the vagina, but often nearly at right angles with it, a sound cannot always be readily passed through this speculum into a normal uterus. The valvular specula are rather better in this respect, but may lead to error in another way, as I have several times seen. Unless carefully managed, the end of that blade which lies along the anterior vaginal wall may very easily be pressed against and be made to indent the anterior wall of the uterus, so as to obstruct the uterine canal to a degree that the sound will not readily pass. The Sims speculum shows its superiority here as elsewhere, but its proper use necessitates the aid of a trained assistant.

Case II. Mrs. N., aged thirty-six. Married at eighteen. Mother of four children, youngest four years old. Has had her present troubles particularly since the birth of her last child, but suffered somewhat before. Had several miscarriages between her first and second children, and with some of her confinements had marked relaxation of the pelvic ligaments, getting much relief at these times by wearing a broad belt buckled very tightly about the pelvis. Menstruation began at thirteen. Always regular each three weeks. Time of flow, six days. Amount normal. No dysmenorrhœa, except slight discomfort first twenty-four hours. Of late years has kept her bed when unwell, by advice of physicians. She formerly had much "bearing down" on walking. Has not had it of late, "simply because she has not walked any distance for four years." When she is on her feet any length of time she has severe pain in her bowels, which is relieved in a measure by hot applications to the abdomen. No backache. At one time suffered much with her head and neck, but does not at present. Cannot walk up and down stairs without subsequent distress, and now never attempts to do so, always making use of an elevator which has been put in the house for her benefit. Her husband tells me that when they were at the sea-side during the summer, she, by actual count, spent sixty-eight days of the time in bed; but being a woman of great energy, when at home she rides out nearly every day, and manages to shop by always sitting as much as possible when in the stores. Her previous attendant thought a supporter might perhaps give her some relief, and called another physician in consultation about the matter; but the consultant advised against a pessary, owing to the tenderness discovered on examination.

In this case the same malposition was found. There was a rupture of the cervix uteri, with eversion, and the womb was larger than usual from subinvolution. While there was quite marked tenderness of the womb itself, which the displacement alone might account for, there was no tenderness of the surrounding tissues, and the organ was freely movable. Under such circumstances a supporter is not contra-indicated, but it is the proper thing to try. Tenderness involving only the uterus, and not extending to the neighboring parts, is no impediment to the use of a supporter; for, properly applied, the latter does not touch the womb.

A pessary was fitted, and the patient cautioned not to expect too much, as nothing could be promised in such a case, and advised to keep rather quiet for the present. She reported in a few days, perfectly delighted, and saying she felt young again. She had astonished her servants by running up and down stairs, and her friends by honoring them with evening calls on foot. The evening after the supporter was applied she spent at the theatre. Moreover, she did not suffer from her indiscretion. Her improvement has continued, and lately she withstood a physical and mental strain, consequent upon sickness and death in her family, which she declares would have completely broken her down but for her greatly improved condition.

Case III. Mrs. C., aged twenty-four. Married at eighteen. Two children, six and four respectively. Two miscarriages, the last two years ago. Menses at fifteen. Always regular. Time of flow seven to ten days. Amount large. Has always had more or less dysmenorrhœa. Better in this respect after her first child, but worse again after her second. Has had uterine symptoms ever since her first child, but has been much worse since her last miscarriage (two years ago), since which she has spent most of the time in her bed. Has constant severe backache, pains in each side and down her limbs. "Is almost crazy" with her head. Unable to sleep, although using anodynes. Nervous, discouraged, and hysterical. Looks haggard and worn out. When she is unwell, and also when she attempts to keep about on her feet, has very severe pain in the right side, which she has been told comes from the ovary. Has also been told that she would never carry a child to term if she became pregnant.

She has been under the care of a homœopath, who applied a pessary, which she shows, and which is so poorly shaped that it could not be of benefit. It soon gave her pain, and she had it removed. Failing to get relief, she was induced to enter as patient an institution whose claims for support are frequently brought before the public by its philanthropic friends. Here she was religiously kept in bed during her stay. That there was an abnormal position of the womb was apparently made out by her attendants, but the plan of treatment which they wished carried out was a decidedly curious one, namely, once or more each day she was to get upon her knees in bed, bury her head in the pillow, elevate her body as high as possible, — thus standing on her head, so to speak, — and remain in this position as long as she could. She tried the method but once; for finding that the head symptoms were anything but benefited by it, she positively de-

clined to try it again. After a stay of five months in the hospital (kept in bed all the time), she was told that her case was a chronic one, and that the institution was not intended for such. She returned home, supposing that her troubles were incurable, and wholly discouraged. I was asked to see the patient by the physician who was next called to her, and requested by him to take the case.

The examination showed much the same condition as in the other cases, except that there was marked tenderness of the right utero-sacral ligament, as is not very uncommon where these ligaments are for a long time overstretched. This condition would account for the pain in the side, which had been attributed to the ovary. It caused some trouble in the fitting of a comfortable supporter. From the first the patient was urged to leave her bed and keep about the house. At the third visit she was found sitting up and playing the piano, and in a few weeks was able to come to my office for what attention was necessary, and to take charge of her household affairs. She has worn her supporter with comfort. I have not been able to discover any condition which would prevent her from carrying a child to full term if she should become pregnant, nor any reason why she should not.

In this case, as in the previous one, there existed rupture of the cervix uteri, with eversion. No attention was paid to the condition, however, as I feel convinced from observation of very many cases that the importance of this lesion has been very much overestimated, and that except in a small minority of cases it does not call for treatment.

Case IV. Mrs. S., aged twenty-eight. Married at eighteen. No children. One miscarriage the year after marriage at about the third month, following a sea voyage, during which she was very ill with seasickness. Menstruation began at sixteen. Before the miscarriage always regular. Time of flow nine days. No pain. Since the miscarriage she has been very irregular, flowing too frequently, and has had severe dysmenorrhœa each time. She has constant backache, "bearing down," bad feeling in head, etc., etc., in short, marked uterine symptoms, which are all increased at the time of her periods. She has been under medical care since she miscarried (now over eight years ago), at first with "regulars," and, not having got relief, of late with "irregulars." Each doctor seemed to treat the case differently from the others, but no one helped her. Her first physician (the one who attended her when she miscarried) told her to wear a supporter, and supplied her with a vaginal bag, which she introduced into the vagina and distended with air. This soon caused pains and tenderness, in fact, increased her sufferings, and after a few days was discarded. Since that time no one has mentioned a supporter to her.

During the past *five years* she has had constant nausea, with occasional vomiting. This trouble has been increasing, so that for over a year she has not been three days without vomiting, which has not unfrequently taken place "a dozen times a day." Her appetite is poor, and she eats "little or nothing." Is somewhat anæmic, but not emaciated. She feels "used up," and for the past four months has kept her bed, and for the last three months of the time has had constant slight uterine flowing. Is unable to sleep, even with medicines. In this state of affairs she called in a member of our society, who, seeing the nature of the case, asked me to see the patient and treat her. Both the lady and her husband were exceedingly anxious to have children. The uterus was found subinvoluted, and its position as in the other cases reported. There was a slight discharge of blood from the os uteri, rather increased by the use of the sound. I made an astringent application to the uterine cavity to check the flow temporarily, and fitted a supporter.

Within a few days the patient was about the house. The supporter needed alteration from time to time, but within six weeks the lady was able to come to town to my office for the necessary attention, and to go about visiting the stores. *She had neither nausea, vomiting, nor flowing from the time the pessary was applied.* Menstruation was perfectly normal for two months. A week after it should have appeared for the third time she came to see me, saying that for about ten days she had had slight nausea each morning, but nothing like as severe as that which she had suffered from so long. She stated that her appetite was very good, and that she had an almost uncontrollable desire for certain dishes, mentioning lobster-salad, which she had not eaten before for years. I expressed the opinion that she was probably pregnant. I met her a few days ago. It is now three months or more since she menstruated, and she has little doubt of her condition. She reported herself as feeling better than for years.

The sudden and complete relief of such severe nausea and vomiting as were present in this case, simply by the use of a supporter to lift the uterus, is interesting and suggestive.

Slight nausea and vomiting, referable to uterine conditions other than pregnancy, are not very rare, and these symptoms, when coincident with a displacement, are often at once relieved or ameliorated by keeping the uterus in its proper place.

Now in the first months of pregnancy, when reflex symptoms are most common, the enlarging womb, until by its growth it lifts itself out of the pelvis, occupies a lower position than usual. If in the non-preguant woman such severe symptoms as were present in this case can be completely relieved by lifting the womb, — regarding the low position of the early pregnant uterus as a possible factor in the causation of nausea and vomiting, — it does not seem unreasonable to suppose that in certain cases, particularly those where the sinking of the organ is exaggerated, the proper use of a supporter may prove an efficient agent in affording relief from this distressing and at times dangerous complication. It seems to me that the subject, although mentioned here and there, has not received the attention which it merits. Certainly the experiment of a supporter is worthy a trial in those cases at least where otherwise a provoked miscarriage would be resorted to. It is needless to add that the pessary should be used with skill and care.

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On certain uterine displacements.